Porter Medical Center, Inc.
Patient Financial Services Department
37 Porter Drive * Middlebury, Vermont 05753 (802) 388-8808

APPLICATION
FOR FINANCIAL ASSISTANCE

Please bring or mail to the Patient Financial Service Department your completed application, along with written proof of individual patient income, for the preceding twelve months from the date of application.

Income includes; earnings, unemployment compensation, workers compensation, social security income, public assistance, veterans payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, alimony, child support, assistance from outside the household and other miscellaneous sources.

Until this office receives the ***completed application, along with your proof of income*** a determination cannot be made. Your account will remain your financial responsibility and we will expect payment according to hospital policy. If mailing your application please mail to Porter Medical Center, Inc. 37 Porter Drive Middlebury, VT 05753.

Financial Assistance is only available for Porter Hospital and Porter Practice Management Services done by Porter employed Physician's that are ***medically necessary services***; non-medically necessary, including elective services are not covered.

If you have any questions, please direct them to our Patient Financial Services Department at 802-388-8808 option 5 and you will be directed to one of our Advocates for assistance, Monday thru Friday from 7:30-4:00.

Sincerely,

Patient Financial Services Department

******Please return this completed application with a COPY of your 2014 W-2 or Federal Income Tax Return (1040) and a Copy of your most recent paystub. If you do not file taxes and your only income is Social Security, please send a COPY of your Social Security Statement.***

If written proof of income is not received, your Financial Assistance Application will be denied.

(Attachment A) - 2015

PORTER HOSPITAL, INC.

And Porter Hospital Owned Physician Practices

STATEMENT OF ZERO INCOME

To be completed by an Applicant whose household has had no income for the past 30 days.

I , ______________________________ , state that no member
(your name)

of my household has received any source of income during the past 30 days.

Our household has been without income ____________________ . I hope and expect to receive
(date)

some income on or about ______________ from ______________________________ .
(date) (list where income will come from)

During the above period, how did your family meet their household needs for:

Food:

____

____

____

Shelter (i.e. housing, heat, electricity):

____

____

____

Living Expenses (i.e. medical bills, car expenses, clothing):

____

____

____

I understand that I can be denied financial assistance for making false statements, and do agree that all answers provided are complete and truthful to the best of my knowledge.

Applicant Signature: ______________________________ Date: ______________

Patient Financial Services
Representative Signature: ______________________________ Date: ______________

Application for Financial Assistance - 2015

PORTER HOSPITAL, INC.

And Porter Hospital Owned Physician Practices

Applicant Name (First and Last): ________________________________ Date of Birth: __ __/__ __/ __ __ __ __

Street address: ____ City/State/Zip: ____

Home Telephone: (   ) ______________________________ Work Telephone: (   ) ____

Current Health Insurance Company: ____________________________ Policy Number: _______________ Group Number: __________

IF YOU ARE UNINSURED, YOU MAY QUALIFY FOR MEDICAID OR A QUALIFIED HEALTH PLAN THROUGH VERMONT HELATH CONNECT.

IF YOU ARE UNSURE PLEASE CONTACT US FOR A NAVIGATOR NEAR YOU FOR ASSISTANCE AT 802-388-8808 OPTION 5.

INCOME:

Wages/Salaries	$
Social Security	$
Pensions	$
Disability/SSI	$
Unemployment Comp	$
Workers Comp	$
Child/Spousal Support	$
VA Benefits	$
Public Assistance	$
Annuities	$
Trusts, Interest/Dividends	$
Other	$
Total Monthly Income	$
Total Annual Income	$

Expenses:

Mortgage/Rent	$
Property Taxes	$
Insurance	$
Automobile	$
Credit Cards (Total)	$
Water/Gas/Oil/Electric	$
Telephone	$
Medical	$
Child/Spousal Support	$
Health Savings Acct	$
Other	$
Total Monthly Expenses	$

HOUSEHOLD MEMBERS reflected on your Federal income tax return:

	Name:	Relationship/Age:
1		Self /
2		Spouse /
3		Dependent/
4		Dependent/
5		Dependent/
6		Dependent/

HOUSEHOLD COUNTABLE RESOURCES (LIQUID ASSETS)

Checking Account	$
Savings Account (incl. seasonal savings accts)	$
Certificates of Deposits	$
Savings Certificates	$
U.S. Savings Bonds	$
Stocks/Bonds	$
Trust Fund	$
Health Savings Accounts (HSA) funds	$
Other (Please Explain)	$

I certify that the information contained in this application is true & complete. I understand that willful falsification of information contained in this application will result in denial of charity care. I am aware that the information provided on this application is subject to verification by Porter Hospital.

X ______________________________ ______________

(Applicant Signature) (Date)

Hospital Use Only -

Approved Date: ____________

Approved for %: ____________

Denied Date: ____________

Reason Denied: ____________

Date Notification Sent: ____________

Pt Financial Advocate: ____________

Account Number(s): ____________

New Balance: ____________

Schedule A

PORTER HOSPITAL AND PORTER HOSPITAL OWNED PHYSICIAN PRACTICES SLIDING SCALE MATRIX 2015

% of Adjusted Gross Income**	100%	80%	60%	40%	20%
Size of Household					
1	$23,540	$28,248	$32,956	$37,664	$42,372
2	$31,860	$38,232	$44,604	$50,976	$57,348
3	$40,180	$48,216	$56,252	$64,288	$72,324
4	$48,500	$58,200	$67,900	$77,600	$87,300
5	$56,820	$68,184	$79,548	$90,912	$102,276
6	$65,140	$78,168	$91,196	$104,224	$117,252
7	$73,460	$88,152	$102,844	$117,536	$132,228
8	$81,780	$98,136	$114,492	$130,848	$147,204

** Adjusted Gross Income based on the 2015 Federal Poverty Guidelines (multiplied by two)

The Guidelines are published in the Federal Register at: www.hhs/gov